A GUIDE TO
PROCEDURE CODES
FOR
CLAIMING MENTAL HEALTH SERVICES

County of Los Angeles – Department of Mental Health
Quality Assurance Division

Robin Kay, PhD
Acting Director of Mental Health

Dennis Murata, M.S.W.
Deputy Director, Program Support Bureau

October 5, 2016

TABLE OF CONTENTS

TABLE OF CONTENTS (CONTINUED)

INTRODUCTION

This Guide, prepared by DMH, lists and defines the compliant codes that the DMH believes reflects the services it provides throughout its system, whether by directly-operated or contracted organizational providers or individual, group, or organizational network providers. This analysis does not, however, absolve Providers, whether individuals or agencies from their responsibility to be familiar with nationally compliant codes and to inform and dialogue with the DMH should they believe differences exist.

Brief History

Since the inception of the DMH's first computer system in 1982, DMH directly-operated and contract staff have reported services using Activity Codes. These Activity Codes were then translated into the types of mental health services for which DMH could be reimbursed through a variety of funding sources. On April 14, 2003, health care providers throughout the Country implemented the HIPAA Privacy rules. This brought many changes to the DMH's way of managing Protected Health Information (PHI), but did not impact the reporting/claiming codes. On October 16, 2003, all health care providers throughout the USA are required to implement the HIPAA Transaction and Codes Sets rules or be able to demonstrate good faith efforts to that end. These rules require that providers of health care services anywhere in the USA must use nationally recognized Procedure Codes to claim services.

HIPAA Objectives and Compliant Coding Systems

One of the objectives of HIPAA is to enable providers of health care throughout the country to be able to be conversant with each other about the services they were providing through the use of a single coding system that would include any service provided. In passing HIPAA, Legislators were also convinced that a single national coding system would simplify the claims work of insurers of health. Two nationally recognized coding systems were approved for use: the Current Procedural Terminology (CPT) codes and the Level II Health Care Procedure Coding System (HCPCS). The CPT codes are five digit numeric codes, such as 90804 and the HCPCS are a letter followed by four numbers, such as H2012.

Definitions found in this Guide are from the following resources: CPT code definitions come from the CPT Codes Manual; HCPCS codes are almost exclusively simply code titles absent definition so these definitions were established either exclusively or in combination from one of these sources – 1) Title 9 California Code of Regulations, Chapter 11, Specialty Mental Health Services, 2) State DMH Letters and Informational Notices, or 3) program definitions such as the Clubhouse Model. Reference citations follow all of the State code definitions.

Implications for Service Delivery

These changes are being made in conjunction with the much larger implementation of a new Management Information System known simply as the Integrated System (IS). In light of all these very extensive changes in the way the DMH reports and claims it's services, it is important to note that, while the DMH will continue to examine its service delivery system and implement creative programs as appropriate, the change from Activity Codes to Procedure Codes is NOT about a change in the services provided by the DMH nor the reimbursement rates for those services. In fact, DMH staff have been diligent in their efforts to ensure that all services that are currently provided have found a place in the new (to the DMH) HIPAA compliant coding system. This will ensure that revenues after October 16, 2003, the implementation date of the new HIPAA compliant Integrated System (IS), will continue to flow into the DMH unchanged from revenues prior to October 16, 2003.

HELPFUL HINTS FOR USING THE GUIDE

DMH directly-operated and contract staff should address **questions and issues** to their supervisors/managers, who may, as needed, contact their Services Area QIC Liaisons for clarifications. Network Providers should contact Provider Relations.

- Readers will quickly note that, except for those services funded entirely by CGF, there are no codes that identify payer information, such as PATH. Payer information will be maintained by funding plan.

- The codes have been categorized into types of services similar to those now in use in order to facilitate the transition to Level I (CPT) and Level II (HCPCS) codes.

- Medicare does not reimburse for travel and documentation time, so in order to appropriately claim to both Medicare and Medi-Cal total service time for the Rendering Provider must be broken out into face-to-face and other time for most services.

- While the basic structure of the tables is the same, many vary in their content because the requirements of different sets of codes are so different.

- The "Rendering Provider" column, which indicated the disciplines allowed to use the specified code, is now entitled "Allowable Discipline(s)." The categories of staff the DMH will continue to recognize are these: physician (MD or DO); licensed or waivered clinical psychologist (PhD or PsyD); licensed or registered Social Worker; licensed or registered MFT; registered nurse (RN); nurse practitioner (NP); clinical nurse specialist (CNS); psychiatric technician (PT); licensed vocational nurse (LVN); mental health rehabilitation specialist (MHRS); and mental health worker (MHW). See Page 7, Reporting Notes, for documentation comments.

- The table heading on each page indicates whether the codes on that page may be used by Network and/or SD/MC Providers. Individual, Group, and Organizational Network Providers may only use codes noted under the Network header. The Table of Contents also indicates whether the codes on a page are applicable to Network, SD/MC, or both.

LIST OF ABBREVIATIONS

- **CGF** – County General Funds
- **CPT** – Current Procedural Terminology; codes established by the American Medical Association to uniquely identify services for reporting and claiming purposes.
- **Disciplines:**

CNS	Clinical Nurse Specialist	Authorized CNS	Authorized Clinical Nurse Specialist
DO	Doctor of Osteopathy		
SW	Social Worker		
LVN	Licensed Vocational Nurse		
PCC	Professional Clinical Counselor		
MD	Medical Doctor		
MFT	Marriage & Family Therapist		
MHRS	Mental Health Rehabilitation Specialist		
MHW	Mental Health Worker		
NP	Nurse Practitioner	Authorized NP	Authorized Nurse Practitioner
PhD	Doctor of Philosophy, Clinical Psychologist		
PsyD	Doctor of Psychology, Clinical Psychologist		
PT	Psychiatric Technician		
RN	Registered Nurse	Authorized RN	Authorized Registered Nurse

- **DMH** – Los Angeles County Department of Mental Health or Department; also known as the Local Mental Health Plan (LMHP)
- **ECT** – Electroconvulsive Therapy
- **FFS** – Fee-For-Service
- **HCPCS** – Health Care Procedure Coding System
- **IMD** – Institutions for Mental Disease
- **IS** – Integrated Systems (formerly known as the MIS, Management Information System)
- **LMHP** – Local Mental Health Plan (in Los Angeles County, the Department of Mental Health)
- **PHI** – Protected Health Information
- **SD/MC** – Short-Doyle/Medi-Cal *(Terminology carried forward from pre-Medi-Cal Consolidation: Medi-Cal Organizational Providers who can be reimbursed for a full range of rehabilitation staff)*
- **SFC** – Service Function Code
- **STP** – Special Treatment Patch
- **TCM** – Targeted Case Management

REPORTING NOTES

DMH directly-operated and contract staff should address **questions and issues** to their supervisors/managers, who may, as needed, contact their Service Area QA Liaison for clarifications. Network Providers should contact Provider Relations.

- **Allowable Disciplines:** Rendering Providers/Practitioners may only provide services consistent with their education/licensure (scope of practice), length of experience and/or job description. All disciplines must minimally have a high school diploma or equivalent.

- **Claiming Payers**: Not all staff listed in the Allowable Discipline(s) column who can report the service may claim to all payer sources. DMH will keep its employees informed, and, as appropriate, its contractors, regarding rules and regulations for service delivery and reimbursement.

- **Face-to-Face time**: Note that for SD/MC Providers, only the psychotherapy codes on page 10 indicate Face-to-Face time. This is because, for the same service, different codes are available and must be selected based on the Face-to-Face time. The absence of Face-to-Face times for other codes only means that time is not a determinant in selecting the code; it does not mean that the code has no Face-to-Face time requirement. Assessment, Psychological Testing, and Individual Medication all require Face-to-Face time that must be both documented in the clinical record and entered into the IS. No other Mental Health, Medication Support, or Targeted Case Management Services require Face-to-Face time, but if it occurs, it should be both noted in the clinical record and entered into the IS. All groups, except Collateral Group, require Face-to-Face time, but that time does not need to be documented in the clinical record or entered into the IS separate from the total time of the contact. Collateral, Team Conference/Case Consultations and No-Contact – Report Writing should always be reported with "0" Face-to-Face time.

- **Telephone Service**: Face-to-Face time is always "0" for telephone contacts. Some procedure codes are not telephone allowable meaning they may not be used for telephone services (see "Face to Face time" above); only those procedure codes specifically identified as telephone allowable may be claimed as a telephone service. For Contract providers submitting electronic claims, the SC modifier must be placed on the procedure code for all telephone services. For Directly-Operated providers in IBHIS, the SC modifier must be on the procedure code for all telephone services. When using the Daily Service Log to report telephone services, the telephone box next to the Service Location Code must be checked. When telephone services are entered into the IS, the "telephone" box on the "Outpatient – Add Service" screen must be checked. This is the only way to ensure that telephone services are claimed to the appropriate payer.

- **Telepsychiatric Service:** For Contract providers submitting electronic claims, the GT modifier must be placed on the procedure code for all telepsychiatric services. For Directly-Operated providers in IBHIS, the GT modifier must be on the procedure code for all telepsychiatric services. When using the Daily Service Log to report telepsychiatric services, the telepsychiatric box next to the telephone box must be checked for all telepsychiatric services. When telepsychiatric services are entered in the IS, the "telepsychiatric" box on the "Outpatient – Add Service" screen must be checked. This is the only way to ensure that telepsychiatric services are appropriately claimed.

PROCEDURE CODES FOR MODE 15
MENTAL HEALTH SERVICES

For more information, refer to the Short-Doyle/Medi-Cal Organizational Provider's Manual page 35.

These services are recorded in the clinical record and reported in the IS/IBHIS in minutes.

CLINICAL ASSESSMENT with CLIENT – SD/MC & NETWORK PROVIDERS (MODE 15)

Assessment services are a required component of Day Treatment Intensive and Day Rehabilitation.
These services will not be separately authorized for clients in one of these programs.

This is an activity that may include a clinical analysis of the history and current status of a client's mental, emotional, or behavioral disorder; relevant cultural issues and history; and diagnosis (CCR §1810.204). These codes should be used when completing an assessment form.

Service	Code	SD/MC Allowable Discipline(s)	Network MC Allowable Discipline(s)
Psychiatric Diagnostic Interview (Client Present)	90791	• MD/DO (Licensed) • PhD/PsyD (Licensed or Waivered) • SW (Licensed, Registered or Waivered) • MFT (Licensed, Registered or Waivered) • Authorized NP or Authorized CNS (Certified) • Authorized RN • PCC (Licensed or Registered) • Student professionals in these disciplines with co-signature	• MD/DO • PhD/PsyD • LCSW • MFT • Authorized NP • Authorized CNS
Psychiatric Diagnostic Interview with Medical Services (Client Present) Must include an in depth evaluation of medical issues	90792	• MD/DO (Licensed) • Authorized NP or Authorized CNS (Certified)	NA

Notes:
- For Directly-Operated clinics, nurses must be authorized to provide Psychiatric Diagnostic Interviews per Policy 200.04. For Contractors, nurses must meet the requirements of the Board of Registered Nursing to be considered authorized.
- These services are reported as SFC 42

PLAN DEVELOPMENT – SD/MC & NETWORK PROVIDERS (MODE 15)

Service	Short-Doyle/Medi-Cal (SD/MC)		Network Medi-Cal	
	Code	**Allowable Discipline(s)**	**Code**	**Allowable Discipline(s)**
Plan Development A stand-alone Mental Health Service that includes developing Client Care Plans, approval of Client Care Plans and/or monitoring of a client's progress. Plan development may be done as part of an interdisciplinary inter/intra-agency conference and/or consultation with other mental health providers in order to develop and/or monitor the client's mental health treatment. Plan development may also be done as part of a contact with the client in order to develop and/or monitor the client's mental health treatment.	H0032**	All disciplines	H0032	• MD/DO or RN (Licensed) • PhD/PsyD (Licensed) • LCSW & MFT (Licensed) • NP or CNS (Certified)

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.

** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone; Directly-Operated providers in IBHIS must include the SC modifier on the procedure code when service is via telephone.

Notes:

- This service is classified as an Individual Mental Health Service and is reported under Service Function 42.
- For Team Conferences: Claimable time should only include the actual time a staff person participated in the conference and any other time a staff person actually spent related to the conference, such as travel or documentation. Participation includes time when information was shared that can be used in planning for client care or services to the client.
- When plan development is done as part of a team conference and/or consultation, it is best practice that only those practitioners who are providing direct services to that client claim. If the practitioner is not providing direct services, there should be detailed documentation to support the practitioner's involvement and time claimed.

INDIVIDUAL PSYCHOTHERAPY (NON-FAMILY) – SD/MC & NETWORK PROVIDERS (MODE 15)

Individual Psychotherapy services that a provider wishes to deliver in conjunction with Day Treatment Intensive or Day Rehabilitation must have authorization from the Department's Central Authorization Unit prior to delivery.

		Short-Doyle/Medi-Cal (SD/MC)			Network Medi-Cal		
Service		**Duration of Face-to-Face**	**Code**	**Allowable Discipline(s)**	**Duration of Face-to-Face**	**Code**	**Allowable Discipline(s)**
Individual Psychotherapy Insight oriented, behavior modifying, and/or supportive psychotherapy delivered to one client.	0 min	0-15 minutes	H0046**	• MD/DO (Licensed) • PhD/PsyD (Licensed or Waivered) • Social Worker (Licensed or registered or waivered) • MFT (Licensed or registered or waivered) • NP or CNS (Certified) • RN (Masters in Psychiatric Mental Health Nursing &listed as a psychiatric-mental health nurse with the BRN) • Professional Clinical Counselor (Licensed or Registered) • Student professionals in these disciplines with co-signature	**Ind, Gp, & Org** 1-19 minutes	NA	• MD/DO (Licensed) • PhD/PsyD (Licensed) • LCSW & • MFT (Licensed) • NP or CNS (Certified) • RN (Masters level within Scope of Practice)
	30 min	16-37 minutes	90832		**Ind, Gp, & Org** 20-39 minutes	90832	
	45 min	38-52 minutes	90834		**Indiv & Group** 40-74 minutes **Org** 40-50 minutes	90834	
	60 min	53+ minutes	90837		**Indiv & Group** 75+ minutes **Org**: NA	**Indiv & Group** 90837 **Org**: NA	

** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone; Directly-Operated providers in IBHIS must include the SC modifier on the procedure code when service is via telephone.

Notes:

- All of these services are classified as Individual Mental Health Services and are reported under Service Function 42.
- When doing telephone therapy, face to face time is always zero and the code used is H0046.

INDIVIDUAL PSYCHOTHERAPY (NON-FAMILY) – SD/MC & NETWORK PROVIDERS (MODE 15)

Individual Psychotherapy services that a provider wishes to deliver in conjunction with Day Treatment Intensive or Day Rehabilitation must have authorization from the Department's Central Authorization Unit prior to delivery.

	Short-Doyle/Medi-Cal (SD/MC)		Network Medi-Cal		
Service	**Code**	**Allowable Discipline(s)**	**Duration of Face-to-Face**	**Code**	**Allowable Discipline(s)**
Psychotherapy for Crisis: Implementation of psychotherapeutic interventions to minimize the potential for psychological trauma while a client is in a crisis state.	90839	• MD/DO (Licensed) • PhD/PsyD (Licensed or Waivered) • Social Worker (Licensed or registered or waivered) • MFT (Licensed or registered or waivered) • NP or CNS (Certified) • RN (Masters in Psychiatric Mental Health Nursing &listed as a psychiatric-mental health nurse with the BRN) • Professional Clinical Counselor (Licensed or Registered) • Student professionals in these disciplines with co-signature	**Ind, Gp, & Org** 40+ minutes	90839	• MD/DO (Licensed) • PhD/PsyD (Licensed) • LCSW & • MFT (Licensed) • NP or CNS (Certified) • RN (Masters level within Scope of Practice)

Notes:

- These services are classified as Individual Mental Health Services and are reported under Service Function 42.
- There must be an objective on the Client Care Plan related to the services provided during Psychotherapy in Crisis or documented discussion of whether or not an objective on the Client Care Plan is needed.

FAMILY AND GROUP SERVICES (except Med Support Group) – SD/MC & NETWORK MC PROVIDERS (MODE 15)

Family and group services that a provider wishes to deliver in conjunction with Day Treatment Intensive or Day Rehabilitation must have authorization from the Department's Central Authorization Unit prior to delivery.

Service	Code (Modifiers*)	Cost Report SFC	SD/MC Allowable Discipline(s)	Network MC Allowable Discipline(s)
Family Psychotherapy with One Client Present Psychotherapy delivered to a family with the intent of improving or maintaining the mental health status of the client. Only one claim will be submitted. **Note:** Family Psychotherapy without the Client Present (90846) is not a reimbursable service through the LMHP – Psychotherapy can only be delivered to an enrolled client. Services to collaterals of clients that fall within the definition of collateral may be claimed under 90887.	90847	**42**	• MD/DO (Licensed) • PhD/PsyD (Licensed or Waivered) • Social Worker (Licensed or registered or waivered) • MFT (Licensed or registered or waivered) • NP or CNS (Certified) • RN (Masters in Psychiatric Mental Health Nursing &listed as a psychiatric-mental health nurse with the BRN) • Professional Clinical Counselor (Licensed or Registered) • Student professional in these disciplines with co-signature	• MD/DO (Licensed) • PhD/PsyD (Licensed) • LCSW & • MFT (Licensed) • NP or CNS (Certified) • RN (Masters level within Scope of Practice)
Family Psychotherapy with More than One Client Present Psychotherapy delivered to a family with the intent of improving or maintaining the mental health status of the client. One claim will be submitted for each client present or represented. **Note:** Family Psychotherapy without the Client Present (90846) is not a reimbursable service through the LAC LMHP – Psychotherapy can only be delivered to an enrolled client. Services to collaterals of clients that fall within the definition of collateral may be claimed under 90887.	90847 (HE, HQ*)	**52**		

(Continued)

FAMILY AND GROUP SERVICES (except Med Support Group) – SD/MC & NETWORK PROVIDERS (MODE 15)

Service	Code (Modifiers*)	SD/MC Allowable Discipline(s)	Network MC Allowable Discipline(s)
Collateral (one or more clients represented) • Gathering information from family or significant support person(s) for the purpose of assessment. • Interpretation or explanation of results of psychiatric examinations or other accumulated data to family or other significant support person(s) • Providing services to family or significant support person(s) for the purpose of assisting the client in his/her mental health treatment (e.g., providing consultation or psychoeducation about client's condition, teaching the family member or significant support person(s) skills that will improve the client's mental health condition).	90887**	All disciplines	NA

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.
** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone; Directly-Operated providers in IBHIS must include the SC modifier on the procedure code when service is via telephone.

Notes:

- A collateral/significant support person is, in the opinion of the client or the staff providing the service, a person who has or could have a significant role in the successful outcome of treatment, including, but not limited to, parent, spouse, or other relative, legal guardian or representative, or anyone living in the same household as the client. Agency staff, including Board & Care operators, are not collaterals.
- These services are classified as Collateral Mental Health Services and are reported under Service Function 10.

(Continued)

FAMILY AND GROUP SERVICES (except Med Support Group) – SD/MC & NETWORK PROVIDERS (MODE 15)

Service	Code (Modifiers*)	SD/MC Allowable Discipline(s)	Network MC Allowable Discipline(s)
Multi-family Group Psychotherapy Psychotherapy delivered to more than one family unit each with at least one enrolled client. Generally clients are in attendance.	90849	• MD/DO (Licensed) • PhD/PsyD (Licensed or Waivered) • Social Worker (Licensed or registered or waivered) • MFT (Licensed or registered or waivered) • NP or CNS (Certified) • RN (Masters in Psychiatric Mental Health Nursing & listed as a psychiatric-mental health nurse with the BRN) • Professional Clinical Counselor (Licensed or Registered) • Student professional in these disciplines with co-signature	• MD/DO (Licensed) • PhD/PsyD (Licensed) • LCSW & • MFT (Licensed) • NP or CNS (Certified) • RN (Masters level within Scope of Practice)
Group Psychotherapy Insight oriented, behavior modifying, supportive services delivered at the same time to more than one non-family client.	90853		
Group Rehabilitation (family and non-family) Service delivered to more than one client at the same time to provide assistance in improving, maintaining, or restoring his/her support resources or his/her functional skills - daily living, social and leisure, grooming and personal hygiene, or meal preparation. §1810.243	H2015 (HE, HQ*)	All disciplines	NA

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.
**Maximum reimbursement for Family Therapy or Collateral for Network Organizational Providers is 90 minutes.

Notes:

- These services are classified as Group Mental Health Services and are reported under Service Function 52.

REHABILITATION (Individual Service, NON-FAMILY) – SD/MC ONLY (MODE 15)

Rehabilitation services that a provider wishes to deliver in conjunction with Day Treatment Intensive or Day Rehabilitation must have authorization from the Department's Central Authorization Unit prior to delivery.

Service	Code	SD/MC Allowable Discipline(s)	Network MC Allowable Discipline(s)
Rehabilitation Service • **Collecting Assessment Information**: Collecting information from non-clients, non-collaterals (e.g. school teachers) for the purpose of determining a mental health diagnosis by practitioners acting within their scope of practice. • **Collecting Information for Substance Use/Abuse Assessment**: Collecting information from the client for the purpose of informing the substance use/abuse assessment (as part of the overall Mental Health Assessment) when done by a Substance Abuse Counselor. • **Individual Rehabilitation Service**: Service delivered to one client to provide assistance in improving, maintaining, or restoring the client's functional, daily living, social and leisure, grooming and personal hygiene, or meal preparation skills, or his/her support resources. CCR §1810.243. • **Psychoeducation to Non-Client, Non-Collateral**: Providing services to non-clients, non-collaterals (e.g., school teachers) for the purpose of assisting the client in his/her mental health treatment (e.g., providing consultation or psychoeducation about client's condition, teaching the non-client, non-collateral person skills that will improve the client's mental health condition).	H2015**	All disciplines	NA
On-going support to maintain employment (This service requires the client be currently employed, paid or unpaid; school is not considered employment.)	H2025**		

** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone; Directly-Operated providers in IBHIS must include the SC modifier on the procedure code when service is via telephone.

Note:

- These services are classified as Individual Mental Health Services and are reported under Service Function 42.

PSYCHOLOGICAL TESTING – SD/MC & NETWORK PSYCHOLOGISTS & PHYSICIANS (MODE 15)

All psychological testing performed by Network Providers and claimed to Medi-Cal must have prior authorization.

Service		Code	SD/MC Allowable Discipline(s)	Network MC Allowable Discipline(s)
Psychological Testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathlogy, eg, MMPI, Rorschach, WAIS)	Face-to-face administration; interpretation and report writing	96101	• PhD/PsyD (Licensed) • MD/DO (Trained)	• PhD/PsyD (Licensed) • MD/DO (Trained)
Psychological Testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathlogy, eg, MMPI, Rorschach, WAIS)	Face-to-face administration; interpretation and report writing	96102	Qualified Health Care Professional*	NA
Psychological Testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology)	Administration by computer; interpretation and report writing	96103	Qualified Health Care Professional*	NA

*For LACDMH, a Qualified Health Care Professional includes:

- Waivered PhD/PsyD
- Doctoral psychology students w/co-signature

Notes:

- Providers must document and submit a claim for the administration of tests on the day of the administration indicating which tests were administered.
- Interpretation and report writing must be completed in accord with documentation timelines in 401.03 by the same person as testing. The note should document tests administered, interpretation, and writing of the report; the interpretation and report writing time should be "Other" time.
- When interpretation and report writing are completed on another day, a separate note for that activity should be documented with no face-to-face time and referencing the report filed in the clinical record. When testing and interpretation and report writing are done by different staff categories (one by licensed and the other by Qualified Health Professional) each staff should document their activities and time independently.
- Scoring time is NOT reimbursable.
- For children, referrals are made to clarify symptomology, rule out diagnoses and help differentiate emotional from learning disabilities.
- These services are reported as SFC 34.

PSYCHOLOGICAL TESTING – SD/MC & NETWORK PSYCHOLOGISTS & PHYSICIANS (MODE 15)

All psychological testing performed by Network Providers and claimed to Medi-Cal must have prior authorization.

Service		Code	SD/MC Allowable Discipline(s)	Network MC Allowable Discipline(s)
Assessment of Aphasia (includes assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI)	Administration by computer; interpretation and report writing	96105	• PhD/PsyD (Licensed) • MD/DO (Trained) • Qualified Health Care Professional*	NA
Developmental Testing; Limited (eg, Developmental Screening Test II, Early Language Milestone Screen)	Interpretation and report writing	96110	• PhD/PsyD (Licensed) • MD/DO (Trained) • Qualified Health Care Professional*	NA
Developmental Testing; Extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments)	Interpretation and report writing	96111	• PhD/PsyD (Licensed) • MD/DO (Trained) • Qualified Health Care Professional*	NA
Neurobehavioral Status Exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities)	Interpretation and report writing	96116	• PhD/PsyD (Licensed) • MD/DO (Trained)	NA
Neuropsychological Testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Care Sorting Test**)**	Face-to-face administration; interpretation and report writing	96118	• PhD/PsyD (Licensed) • MD/DO (Trained)	• PhD/PsyD (Licensed) • MD/DO (Trained)
Neuropsychological Testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Care Sorting Test)	Face-to-face administration; interpretation and report writing	96119	• Qualified Health Care Professional*	NA
Neuropsychological Testing (e.g., Wisconsin Card Sorting Test)	Administration by computer; interpretation and report writing	96120	• Qualified Health Care Professional*	NA
Standardized Cognitive Performance Testing (eg, Ross Information Processing Assessment)	Face-to-face administration; interpretation and report writing	96125	• Qualified Health Care Professional*	NA

*For LACDMH, a Qualified Health Care Professional includes:

- Waivered PhD/PsyD
- Doctoral psychology students w/co-signature

Notes: See Notes on page 17

OTHER MENTAL HEALTH SERVICES – SD/MC & NETWORK PROVIDERS (MODE 15)

Service	Code	SD/MC Allowable Discipline(s)
Review of Records Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for: • Assessment and/or diagnostic purposes • Plan Development (development of client plans and services and/or monitoring a client's progress) when not in the context of another service	90885	All disciplines .
No contact – Report Writing Preparation of reports of client's psychiatric status, history, treatment, or progress to other treating staff for care coordination when not part of another service	90889	All disciplines

Notes:

- All of these services are classified as Individual Mental Health Services and are reported under Service Function 42.
- When claiming for Review of Records, there must be clear documentation regarding how the information reviewed will inform the assessment, diagnosis and/or treatment plan.
- No contact – Report Writing does not include activities such as writing letters to notify clients that their case will be closed
- Completing Form 1002 can be reimbursed by invoicing the Social Security Administration (SSA). For instructions on how to invoice the SSA click on the following link: http://dmhhqportal1/sites/RMD/RMD%20Bulletins%20%20Directly%20Operated%20Programs/2016%20CBO%20Dispatch/DMH%20CBO%20Dispatch%2016-032%20-%20Invoicing%20Social%20Security%20for%20Completing%201002s.pdf

SERVICES TO SPECIAL POPULATIONS – SD/MC ONLY (MODE 15)

Service	Code	SFC	SD/MC Allowable Discipline(s)
MAT - Case Conference Attendance MAT Team Meeting time that cannot be claimed to Medi-Cal	G9007**	42	All disciplines
Intensive Home Based Services (IHBS) Individual Rehab and Collateral services to Katie A. Subclass members provided with significant intensity to address the intensive mental health needs of the child/youth and predominantly delivered outside the office setting.	H2015HK**	57	

**Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone; Directly-Operated providers in IBHIS must include the SC modifier on the procedure code when service is via telephone.

Service	Code, (Modifier*)	SFC	SD/MC Allowable Discipline(s)
Therapeutic Behavior Services	H2019** (HE*)	58	All disciplines

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.
** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone.

MODE 15: MEDICATION SUPPORT SERVICES

For more information, refer to the Short-Doyle/Medi-Cal Organizational Provider's Manual page 37

These services are recorded in the clinical record and reported in the IS/IBHIS in minutes.

MEDICATION SUPPORT – SD/MC PHYSICIANS & NURSE PRACTITIONERS (MODE15)
EVALUATION AND MANAGEMENT

- *Evaluation and Management (E&M) procedure codes are utilized by SD/MC Physicians and Nurse Practitioners when providing face-to-face Medication Support Services for the purpose of medication evaluation and prescription.*
- *There is a set of E&M procedure codes for "Office/Other Outpatient Services" and a set for "Home" services; there is also a set for "New Clients" and a set for "Established Clients". For the purposes of E&M procedure codes, a new client is defined as someone who has not been seen by an MD/DO/NP within the past three years at the same Billing Provider/Reporting Unit for the purposes of E&M procedure codes.*
- *The E&M procedure code should be chosen based on: History, Examination and Medical Decision Making. See the grid below for additional information regarding these elements.*
- *Time is NOT a determining factor in the choice of the E&M procedure code.*

Component	Determining Factors	Types and Elements of each Type
History	**Refers to the amount of history that is gathered** which is dependent upon clinical judgment and on the nature of the presenting problem(s).	**Problem focused** - chief complaint, brief history of present illness or problem **Expanded problem focused** – chief complaint, brief history of present illness, problem pertinent system review **Detailed** – chief complaint, extended history of present illness, problem pertinent system review extended to include a review of a limited number of additional systems, pertinent past/family/and or social history directly related to the client's problems **Comprehensive** – chief complaint, extended history of present illness, review of systems that is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems, complete past/family/social history
Examination	**Refers to the body and/or organ systems that are examined** which is dependent on clinical judgment and on the nature of the presenting problem(s). "Psychiatric" is considered an Organ System and must be included in the examination. Additional Organ Systems include: Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Skin, Neurologic, Hematologic/Lymphatic/Immunologic. Additional Body Systems include: Head (including the face), Neck, Chest (including breasts and axilla), Abdomen, Genitalia/Groin/Buttocks, Back, Each Extremity	**Problem focused** – a limited examination of the affected body area or organ system **Expanded problem focused** – a limited examination of the affected body area or organ system and other symptomatic or related organ system(s) **Detailed** – an extended examination of the affected body area(s) and other symptomatic or related organ system(s) **Comprehensive** – a general multisystem examination or a complete examination of a single organ system
Medical Decision Making	**Refers to the complexity of establishing a diagnosis and/or selecting a management option** based on 1) the number of diagnoses and/or management options 2) the amount and/or complexity of medical records, diagnostic tests and/or other information that must be obtained, reviewed, analyzed 3) the risk of significant complications, morbidity, and/or mortality associated with the presenting problem (s), diagnostic procedure(s) and/or possible management options	**Straightforward** – minimal diagnoses and/or management options, minimal or no data to be reviewed, minimal risk of complications **Low complexity** - limited diagnoses and/or management options, limited data to be reviewed, low risk of complications **Moderate complexity** - multiple diagnoses and/or management options, moderate data to be reviewed, moderate risk of complications **High complexity** - extensive diagnoses and/or management options, extensive data to be reviewed, high risk of complications

MEDICATION SUPPORT – SD/MC PHYSICIANS & NURSE PRACTITIONERS (MODE15)

EVALUATION AND MANAGEMENT - OFFICE OR OTHER OUTPATIENT SERVICES

This service cannot be delivered in an Inpatient Place of Service

Service	New Client	Severity of Presenting Problem(s)	Required Components	SD/MC Allowable Discipline(s)
Office or other outpatient visit for the evaluation and management of a new patient which requires all three (3) components listed in the "Required Components" column Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	99201	Minor	• problem focused history • problem focused examination • straightforward medical decision making	• MD/DO • NP
	99202	Low to Moderate	• expanded problem focused history • expanded problem focused exam • straightforward medical decision making	
	99203	Moderate	• detailed history • detailed examination • medical decision making of low complexity	
	99204	Moderate to High	• comprehensive history • comprehensive examination • medical decision making of moderate complexity	
	99205	Moderate to High	• comprehensive history • comprehensive examination • medical decision making of high complexity	

*Plus CPT modifiers, when appropriate

Notes:

- These services are SFC 62.

MEDICATION SUPPORT – SD/MC PHYSICIANS & NURSE PRACTITIONERS (MODE15)

EVALUATION AND MANAGEMENT - OFFICE OR OTHER OUTPATIENT SERVICES

This service cannot be delivered in an Inpatient Place of Service

Service	Established Client	Severity of Presenting Problem(s)	Required Components (Minimum 2 of 3)	SD/MC Allowable Discipline(s)
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two (2) of the three (3) components listed in the "Required Components" column Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	99212	Minor	• problem focused history • problem focused examination • straightforward medical decision making	• MD/DO • NP
	99213	Low to Moderate	• expanded problem focused history • expanded problem focused exam • medical decision making of low complexity	
	99214	Moderate to High	• detailed history • detailed examination • medical decision making of moderate complexity	
	99215	Moderate to High	• comprehensive history • comprehensive examination • medical decision making of high complexity	

*Plus CPT modifiers, when appropriate

Notes:

- These services are SFC 62.

MEDICATION SUPPORT – SD/MC PHYSICIANS & NURSE PRACTITIONERS (MODE15)

EVALUATION AND MANAGEMENT - HOME SERVICES

Place of Service must be Home (12)

Service	New Client	Severity of Presenting Problem(s)	Required Components	SD/MC Allowable Discipline(s)
Home visit for the evaluation and management of a new patient which requires all three (3) components listed in the "Required Components" column Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	99341	Low	• problem focused history • problem focused examination • straightforward medical decision making	• MD/DO • NP
	99342	Moderate	• expanded problem focused history • expanded problem focused exam • medical decision making of low complexity	
	99343	Moderate to High	• detailed history • detailed examination • medical decision making of moderate complexity	
	99344	High	• comprehensive history • comprehensive examination • medical decision making of moderate complexity	
	99345	Unstable or a significant new problem	• comprehensive history • comprehensive examination • medical decision making of high complexity	

*Plus CPT modifiers, when appropriate

Notes:

- These services are SFC 62.

MEDICATION SUPPORT – SD/MC PHYSICIANS & NURSE PRACTITIONERS (MODE15)

EVALUATION AND MANAGEMENT - HOME SERVICES

Place of Service must be Home (12)

Service	Established Client	Severity of Presenting Problem(s)	Required Components (2 of the 3)	SD/MC Allowable Discipline(s)
Home visit for the evaluation and management of a new patient which requires at least two (2) of the three (3) components listed in the "Required Components" column Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	99347	Minor	• problem focused history • problem focused examination • straightforward medical decision making	• MD/DO • NP
	99348	Low to Moderate	• expanded problem focused history • expanded problem focused exam • medical decision making of low complexity	
	99349	Moderate to High	• detailed history • detailed examination • medical decision making of moderate complexity	
	99350	Moderate to High	• comprehensive history • comprehensive examination • medical decision making of moderate to high complexity	

*Plus CPT modifiers, when appropriate

Notes:

- These services are SFC 62.

MEDICATION SUPPORT – SD/MC & NETWORK PHYSICIANS & NURSE PRACTITIONERS (MODE 15)

	Short-Doyle/Medi-Cal (SD/MC)		Network Medi-Cal	
Service	**Code (Modifier*)**	**Allowable Discipline(s)**	**Code (Modifier*)**	**Allowable Discipline(s)**
Individual Medication Service (Face-to-Face) This service requires expanded problem-focused or detailed history and medical decision-making of low to moderate complexity for prescribing, adjusting, or monitoring meds.	NA	NA	99201 **Indiv & Group** 15+ minutes **Organizational** 15-50 minutes	• MD/DO • NP
Brief Medication Visit (Face-to-Face) Brief office visit for the sole purpose of monitoring or changing medication prescriptions. This service typically requires only a brief or problem-focused history including evaluation of safety & effectiveness with straightforward decision-making regarding renewal or simple dosage adjustments. The client is usually stable. Not to be used for new clients.	NA		99212 **I&G**: 7+ min **Org**: 7-50 min	
Intramuscular Injections Used for administering intramuscular injections as ordered by an MD, DO or NP.	96372	• MD/DO • NP/CNS • RN • LVN • PT • Pharmacist*** • Student professionals in these disciplines	N/A	N/A
Oral Medication Administration Used for single or multiple administration at one time of oral medications as ordered by an MD, DO or NP.	H0033		N/A	N/A
Comprehensive Medication Service Medication Support Services to clients, collaterals, and/or other pertinent parties (e.g. PCP). Services may include: Prescription by phone, medication education by phone or in person, discussion of side effects by phone or in person, medication plan development by phone or in person, and medication group in person.	H2010** (HE*)		N/A	N/A

* Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.
** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone; Directly-Operated providers in IBHIS must include the SC modifier on the procedure code when service is via telephone.
***Per the Pharmacist laws and regulations, an agency must have policies and procedures in place in order for a pharmacist to administer injections.

Notes:

- All Medication Support Services are claimed as Service Function Code 62.

MODE 15: CRISIS INTERVENTION

For more information, refer to the Short-Doyle/Medi-Cal Organizational Provider's Manual page 39

These services are recorded in the clinical record and reported in the IS/IBHIS in minutes.

CRISIS INTERVENTION (MODE 15) – SD/MC ONLY

Service	Code (Modifiers*) Place of Service (POS)	SFC	Allowable Discipline(s)
Crisis Intervention A service lasting less than 24 hours which requires more timely response than a regularly scheduled visit and is delivered at a site other than a Crisis Stabilization program. (§1810.209)	H2011** (HE*)	**77**	All disciplines

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.
** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone; Directly-Operated providers in IBHIS must include the SC modifier on the procedure code when service is via telephone.
.

Notes:

- Medi-Cal limits reimbursement for H2011 to eight hours (480 minutes) per client per day

MODE 15: TARGETED CASE MANAGEMENT

For more information, refer to the Short-Doyle/Medi-Cal Organizational Provider's Manual page 40

These services are recorded in the clinical record and reported in the IS/IBHIS in minutes.

TARGETED CASE MANAGEMENT – SD/MC & NETWORK PROVIDERS (MODE 15)

	Short-Doyle/Medi-Cal (SD/MC)		Network Medi-Cal Organizational Providers ONLY	
Service	**Code**	**Allowable Discipline(s)**	**Code**	**Allowable Discipline(s)**
Targeted Case Management (TCM) Services needed to access medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Services include linkage and consultation, placement, and plan development in the context of targeted case management services.	T1017** (HE, HS*)	Any staff operating within his/her scope of practice.	**T1017** (HE, HS*)	• MD/DO or RN (Licensed) • PhD/PsyD (Licensed) • LCSW & MFT (Licensed) • NP or CNS (Certified):

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.
** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone; Directly-Operated providers in IBHIS must include the SC modifier on the procedure code when service is via telephone.

Notes:
- All of these services are classified as Targeted Case Management and are reported under Service Function 04.

SERVICES TO SPECIAL POPULATIONS – SD/MC ONLY (MODE 15)

Service	Code	SD/MC Allowable Discipline(s)
Intensive Care Coordination (ICC) Targeted Case Management services to Katie A. Subclass members to facilitate the implementation of a cross-system/multi-agency collaborative services approach. Includes assessing needs, service planning and implementation, monitoring and adapting and transition.	T1017HK**	All disciplines

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.
** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone; Directly-Operated providers in IBHIS must include the SC modifier on the procedure code when service is via telephone.

Notes:
- All of these services are classified as Intensive Care Coordination and are reported under Service Function 07.

MODE 10: CRISIS STABILIZATION, DAY TREATMENT INTENSIVE, DAY REHABILITATION, SOCIALIZATION & VOCATIONAL SERVICES

For more information, refer to the Short-Doyle/Medi-Cal Organizational Provider's Manual page 48

CRISIS STABILIZATION (MODE 10) – SD/MC ONLY

Service	Code (Modifiers*) Place of Service (POS)	SFC	Allowable Discipline(s)
Crisis Stabilization – Emergency Room A package program lasting less than 24 hours delivered to clients which requires more timely response than a regularly scheduled visit	S9484 (HE, TG*) POS - 23	**24**	Bundled service not claimed by individual staff. Specific staffing requirements are in §1840.348
Crisis Stabilization – Urgent Care Facility A package program lasting less than 24 hours delivered to clients which requires more timely response than a regularly scheduled visit	S9484 (HE, TG*) POS - 20	**25**	Bundled service not claimed by individual staff. Specific staffing requirements are in §1840.348

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.
** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone.

Notes:

- **Crisis Stabilization services** are recorded in the clinical record and reported into the IS in hours.

DAY REHABILITATION AND DAY TREATMENT INTENSIVE – SD/MC ONLY (MODE 10)

All of these services must be authorized by the Department prior to delivery and claiming. The requirement for prior authorization also extends to outpatient mental health services planned for delivery on the same day the client is in one of these day programs.

Service	Program Duration	Code (Modifiers*)	SFC	Allowable Discipline(s)
Day Rehabilitation A structured program of rehabilitation and therapy provided to a distinct group of beneficiaries in a therapeutic milieu to improve, maintain, or restore personal independence and functioning, consistent with requirements for learning and development. (§1810.212)	**Half Day:** more than 3 continuous hrs but less than 4/day	H2012 (HQ*)	**92**	Bundled service not claimed by individual staff. All disciplines One of these disciplines must be included in the staffing: MD/DO, RN, PhD/PsyD, LCSW, MFT.
	Full Day: exceeds 4 continuous hrs/day	H2012 (HE*)	**98**	
Day Treatment Intensive A structured, multi-disciplinary program of therapy provided to a distinct group of clients in a therapeutic milieu that may: be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting. (§1810.213)	**Half Day:** more than 3 continuous hrs but less than 4/day	H2012 (HQ TG*)	**82**	
	Full Day: exceeds 4 continuous hrs/day	H2012 (HE, TG*)	**85**	

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.

Notes:

- These services are recorded in the clinical record and reported into the IS as either full day or half day.

SOCIALIZATION SERVICES – SD/MC ONLY (MODE 10)

These services are neither Medicare nor SD/MC reimbursable.

Service	Code, (Modifier*)	SFC	Allowable Discipline(s)
Socialization Day Services This service is a bundled activity service designed for clients who require structured support and the opportunity to develop the skills necessary to move toward more independent functioning. The activities focus on recreational and/or socialization objectives and life enrichment. The activities include but are not limited to outings, recreational activities, cultural events, linkages to community social resources, and other social supportive maintenance efforts. Services may be provided to clients with a mental disorder who might otherwise lose contact with social or treatment systems.	H2030 (HX*)	**41**	Bundled service not claimed by individual staff. All disciplines

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.

VOCATIONAL SERVICES – SD/MC ONLY (MODE 10)

These services are neither Medicare nor SD/MC reimbursable.

Service	Code	SFC	Allowable Discipline(s)
Vocational Day Services (Skill Training and Development) This bundled service is designed to encourage and facilitate individual motivation and focus upon realistic and attainable vocational goals. To the extent possible, the intent of these services is to maximize individual client involvement in skill seeking enhancement with an ultimate goal of self-support. These vocational services shall be bundled into a milieu program for chronically and persistently mentally ill clients who are unable to participate in competitive employment. These programs include, but are not limited to vocational evaluation, pre-vocational, vocational, work training, sheltered workshop, and job placement. The program stresses development of sound work habits, skills, and social functioning for marginally productive persons who ultimately may be placed in work situations ranging from sheltered work environments to part or full-time competitive employment.	H2014	**31**	Bundled service not claimed by individual staff. All disciplines .

Notes:

- These services are recorded in the clinical record and reported into the IS in units of 4 hour blocks of time.

MODE 45 & 60: COMMUNITY OUTREACH & CASE MANAGEMENT SERVICES

For more information, refer to the Community Outreach Services Manual

COMMUNITY OUTREACH SERVICES (MODE 45) AND CASE MANAGEMENT SUPPORT (MODE 60) - SD/MC ONLY

These are indirect services and are neither Medicare nor SD/MC reimbursable.

Service	Code	SFC	Allowable Discipline(s)
Community Outreach Service - Mental Health Promotion Services delivered in the community-at-large to special population groups, human service agencies, and to individuals and families who are not clients of the mental health system. Services shall be directed toward: 1) enhancing and/or expanding agencies' or organizations' knowledge and skills in the mental health field for the benefit of the community-at-large or special population groups, and 2) providing education and/or consultation to individuals and communities regarding mental health service programs in order to prevent the onset of mental health problems.	200**	**10**	All disciplines
Community Outreach Service - Community Client Services Services delivered in the community-at-large to special population groups, human service agencies, and to individuals and families who are not clients of the mental health system. Services shall be directed toward: 1) assisting individuals and families for whom no case record can be opened to achieve a more adaptive level of functioning through a single contact or occasional contacts, such as suicide prevention or other hotlines, and 2) enhancing or expanding the knowledge and skills of human services agency staff in meeting the needs of mental health clients.	231**	**20**	
Case Management Support System-oriented services that supplement direct case management services such as: developing the coordination of systems and communications concerning the implementation of a continuum of care, establishing systems of monitoring and evaluating the case management system, and facilitating the development and utilization of appropriate community resources.	6000**	60	

** Services may be provided via telephone. Because services are not claimed electronically, no modifier is required.

Notes:

- These services are recorded in the clinical record and reported into the IS in units of 15 minute increments.

MODE 5: RESIDENTIAL & OTHER SUPPORTED LIVING SERVICES

For more information, refer to the Short-Doyle/Medi-Cal Organizational Provider's Manual page 64

RESIDENTIAL & OTHER SUPPORTED LIVING SERVICES – SD/MC ONLY (MODE 05)

Service	Code (Modifiers*)	Facility Type	Cost Report Mode 05 SFC	Medi-Cal Mode	Allowable Discipline(s)
Psychiatric Health Facility	H2013	11	**20**	05	Per diem service not claimed by individual staff
Crisis Residential	H0018	86	**43** 44	05	
Transitional Residential – Non-Medi-Cal	H0019 (HC*)	86	**60** 61 64	05	
Transitional Residential – Transitional	H0019	86	**65** 67	05	
Transitional Residential – Long Term	H0019 (HE*)	86	**70** 71	05	
Residential Pass Day	0183 (HB*)	86	**62**	NA	
Semi-Supervised Living	H0019 (HX*)	86	**80** 81 85 86	NA	
Life Support/Interim Funding	0134	86	**40**	NA	

*Contract providers submitting <u>electronic</u> claims to the Department must attach the letter modifiers in the claims transmission.

Notes:

- These services are recorded in the clinical record and reported into the IS as days.

STATE HOSPITAL, IMD, & MH REHABILITATION CENTER SERVICES – SD/MC ONLY (MODE 05)

Service		Code (Modifiers*)	Facility Type	Cost Report Mode 05 SFC	Medi-Cal Mode	Allowable Discipline(s)
State Hospital Facility		0100	89	**01**	NA	Per diem service not claimed by individual staff
Skilled Nursing Facility – Acute Intensive		0100 (HB*)	21	**30**	NA	
Institutions for Mental Disease (IMD) **WITHOUT** Special Treatment Patch (STP)	under 60 beds (Laurel Park. Provider #0058)	0100 (HE*)	89	**35**	NA	
	60 beds & over (Olive Vista, Provider #0061)	0100 (HE, GZ*)		**35**		
	Indigent	0100 (HX*)		**36**		
Institutions for Mental Disease (IMD) **WITH** Special Treatment Patch (STP)	Subacute, Forensic History in County (Olive Vista, Provider #0061),	0100 (HE, TG*)	89	**36**	NA	
	Subacute, Forensic History Out of County	0100 (HE, TN*)		**37**		
	Non-MIO/Hearing Impaired (Sierra Vista, Provider #0066)	0100 (HK*)		**36**		
	MIO (Olive Vista, Provider #0061),	0100 (HB, HZ*)		**37**		
	Indigent MIO (Olive Vista, Provider #0061),	0100 (TG*)		**38**		
	Subacute, Forensic History, Indigent Olive Vista, Provider #0061),	0100 (HB, TG*)		**39**		
	Subacute, Forensic History, Indigent Out of County	0100 (HB, TN*)		**39**		
	Hearing Impaired (Laurel Park, Provider #0058)	0100 (HB, HK*)		**36**		
IMD Pass Day		0183	89	**39**	NA	
MH Rehabilitation Center	Level One	0100 (GZ*)	86	**90**	NA	
	Level Two	100 (GZ, HE*)		**91**		
	Level Three	100 (GZ, HK*)		**92**		

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.

Notes:

- These services are recorded in the clinical record and reported into the IS as days.

ACUTE INPATIENT FACILITY SERVICES (MODE 05)

Service	Code, (Modifiers*)	Facility Type	SFC	SD/MC Mode	Allowable Discipline(s)
Acute Days					
Acute General Hospital	0100 (AT, HT*)	11	**10**	07	Per diem service not claimed by individual staff
Acute General Hospital – PDP	0100 (AT*)	11	**10**	NA	
Acute General Hospital - CGF	0100 (AT, HX*)	11	**10**	NA	
Local Psychiatric Hospital, age 21 or under	0100 (HA*)	11	**14**	08	
Local Psychiatric Hospital, age 22-64	0100 (HB*)	11	**15**	NA	
Local Psychiatric Hospital, age 65 or over	0100 (HC*)	11	**15**	09	
Local Psychiatric Hospital, Adult Forensic	0100 (HX)	11	**12**	NA	
Local Psychiatric Hospital, PDP	0100 (SC*)	11	**15**	NA	
Forensic Inpatient Unit	0100 (HZ*)	89	**50**	NA	
Administrative Days					
Acute General Hospital	0101 (HE*)	11	**19**	07	Per diem service not claimed by individual staff
Local Psychiatric Hospital, age 21 or under	0101 (HA*)	11		08	
Local Psychiatric Hospital, age 22-64	0101 (HB*)	11		NA	
Local Psychiatric Hospital, age 65 or over	0101 (HC*)	11		09	
Psych Hospital, PDP	0101	11		NA	
Acute Hospital, PDP	0101 (HX*)	11		NA	

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.

Notes:

- These services are recorded in the clinical record and reported into the IS as days.

ELECTROCONVULSIVE THERAPY (ECT) (MODE 15)
NETWORK INDIVIDUAL & GROUP PHYSICIANS ONLY

This service may only be delivered in an Outpatient Hospital (Place of Service Code 22)

Service	Type	Code*	Allowable Discipline(s)
ECT including monitoring	Single seizure	90870	Network MD/DO only
	Multiple seizures/day	90871	

*Plus CPT modifiers, when appropriate

Notes:

- These services are categorized in the data system as Medication Support Services and are recorded in the clinical record and reported into the IS in hours:minutes.

EVALUATION AND MANAGEMENT - HOSPITAL INPATIENT SERVICES (MODE 15)

NETWORK PHYSICIANS and ADMITTING PSYCHOLOGISTS ONLY

This service may only be delivered at one of these locations: Inpatient Hospital (Place of Service Code 21)

Service	Components	Severity of Condition	Duration of Face-to-Face or on Unit	Code*	Allowable Discipline(s)
Initial Care The first hospital encounter the admitting physician has with a client on the inpatient unit for the management and evaluation of a new client that requires three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• detailed history • detailed or comprehensive exam • straight-forward or low complexity decision-making	Low	**Ind, Gp, & Org** 1-29 minutes	99221	Network MD/DO and Admitting Psychologists only
	• comprehensive history • comprehensive examination • decision-making of moderate complexity	Moderate	**Indiv & Group** 30-69 minutes Org 30-45 minutes	99222	
	• comprehensive history • comprehensive examination • decision-making of high complexity	High	**Indiv & Group** 70+ minutes **Organizational** 30-45 minutes	99223	
Subsequent Care, per day, for the evaluation and management of a client that requires at least two of three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• Problem focused history • Problem focused examination • straight-forward or low complexity decision-making	Stable, recovering, or improving	**Ind, Gp, & Org** 1-24 minutes	99231	
	• expanded problem focused history • expanded problem focused exam • decision-making of moderate complexity	Inadequate response to therapy or minor complication	**Ind, Gp, & Org** 25-34 minutes	99232	
	• detailed history • detailed examination • decision making of moderate to high complexity	Unstable, Significant complication, or new problem	**Indiv & Group** 35+ minutes **Organizational** 35-45 minutes**	99233	
Discharge	All services on day of discharge	N/A	**Ind, Gp, & Org** 1-24 minutes	99238	
			I&G: 25+ min **Org**: 25-45 min**	99239	

*Plus CPT modifiers, when appropriate

** Maximum reimbursement is for 45 minutes of service.

Notes:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in hours:minutes.

EVALUATION & MANAGEMENT - NURSING FACILITY (MODE 15)
NETWORK PHYSICIANS ONLY

This service may be delivered at any of these locations: Skilled Nursing Facility (Place of Service Code 31), Nursing Facility (POS Code 32), Intermediate Care Facility/Mentally Retarded (POS Code 54), Residential Substance Abuse Treatment Facility (POS Code 55), or Psychiatric Residential Treatment Center (POS Code 56).

Service	Components	Severity of Condition and/or Plan Requirements	Duration of Face-to-Face or on Unit	Code*	Allowable Discipline(s)
Assessment Annual assessment for the evaluation and management of a new or established client that requires three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• detailed history • comprehensive examination • straight-forward or low complexity decision-making	Stable, recovering, or improving; Affirmation of plan of care required	**Ind, Gp, & Org** 20-39 minutes	99301	Network MD/DO only
	• detailed history • comprehensive examination • decision-making of moderate to high complexity	Significant complication or new problem; New plan of care required	**Ind, Gp, & Org** 40-49 minutes	99302	
	• comprehensive history • comprehensive examination • decision-making of moderate to high complexity	Creation plan of care required	**Indiv & Group** 50+ minutes **Organizational** 50 minutes**	99303	
Subsequent Care, per day, for the evaluation and management of a new or established client that requires three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• Problem focused history • Problem focused examination • straight-forward or low complexity decision-making	Stable, recovering, or improving	**Ind, Gp, & Org** 1-19 minutes	99311	
	• expanded history • expanded examination • decision-making of moderate complexity	Inadequate response to therapy or minor complication	**Ind, Gp, & Org** 20-39 minutes	99312	
	• detailed history • detailed examination • decision making of moderate to high complexity	Unstable, Significant complication or new problem	**Indiv & Group** 40+ minutes **Organizational** 41-50 minutes**	99313	
Discharge	All services on day of discharge	N/A	**Ind, Gp, & Org** 20-39 minutes	99315	
			I&G: 40+ min **Org**: 41-50 min**	99316	

*Plus CPT modifiers, when appropriate

** Maximum reimbursement is for 50 minutes of service.

Notes:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in hours:minutes.

EVALUATION AND MANAGEMENT
DOMICILIARY, BOARD & CARE, OR CUSTODIAL CARE FACILITY (MODE 15)
NETWORK PHYSICIANS ONLY

This service may only be delivered at a Custodial Care Facility (Place of Service Code 33)
It will be categorized in the data system as an Individual Service.

Service	Components	Severity of Presenting Problem	Code*	Allowable Discipline(s)
New Client Service for the evaluation and management of a new client that requires three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• Problem focused history • Problem focused examination • straight-forward or low complexity decision-making	Low	99321	Network MD/DO only
	• expanded history • expanded examination • decision-making of moderate	Moderate	99322	
	• detailed history • detailed examination • decision-making of high complexity	High	99323	
Established Client Services for the evaluation and management of an established client that requires at least two of three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• Problem focused history • Problem focused examination • straight-forward or low complexity decision-making	Stable, recovering, or improving	99331	
	• expanded history • expanded examination • decision-making of moderate complexity	Inadequate response to therapy or minor complication	99332	
	• detailed history • detailed examination • decision making of high complexity	Significant complication or new problem	99333	

*Plus CPT modifiers, when appropriate
** Maximum reimbursement for Network Organizational MD/DO is for 50 minutes of service.

Notes:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in hours:minutes.

EVALUATION AND MANAGEMENT - OFFICE OR OTHER OUTPATIENT SERVICES (MODE 15)
NETWORK PHYSICIANS ONLY

This service may be only be delivered in an Office (Place of Service Code 11)

Service	Components	Severity of Presenting Problem(s)	New Client	Established Client	Allowable Discipline(s)
			Duration of Face-to-Face with Client and/or Family and Code*	**Duration of Face-to-Face with Client and/or Family and Code***	
Evaluation and management of a client that includes at least the three components noted in the next column. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• problem focused history • problem focused examination • straightforward medical decision making	Minor	No Code	No Code	Network MD/DO only
	• expanded problem focused history • expanded problem focused exam • straightforward medical decision making	Low to Moderate	**Ind, Gp, & Org** 20-29 minutes 99202	No Code	
	• detailed history • detailed examination • medical decision making of low complexity	Moderate	**Ind, Gp, & Org** 30-39 minutes 99203	**Ind, Gp, & Org** 20-24 minutes 99213	
	• comprehensive history • comprehensive examination • medical decision making of moderate complexity	Moderate to High	**Indiv & Group** 40-59 minutes **Org**: 40-50 minutes 99204**	**Ind, Gp, & Org** 25-39 minutes 99214	
	• comprehensive history • comprehensive examination • medical decision making of high complexity	Moderate to High	**Indiv & Group** 60+ minutes 99205 **Org**: NA	**Indiv & Group** 40+ minutes 99215 **Org**:Not Reimbursed	

*Plus CPT modifiers, when appropriate
**Maximum reimbursement for Network Organizational MD/DO is for 50 minutes of service.

Notes:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in hours:minutes,

EVALUATION AND MANAGEMENT – CONSULTATIONS, OFFICE OR OTHER OUTPATIENT (MODE 15)
DEPT OF HEALTH SERVICES & NETWORK PHYSICIANS & PSYCHOLOGISTS

This service may be delivered in any setting other than Inpatient Hospital: Office (Place of Service Code 11), Home (POS 12), Urgent Care (POS 20), Outpatient Hospital (POS 22), Hospital ER (POS 23), Ambulatory Surgical Center (POS 24), Skilled Nursing Facility (POS 31), Nursing Facility (POS 32), Custodial Care Facility (POS 33), Hospice (POS 34)

Service	Components	Presenting Problems	Duration of Face-to-Face, Client and/or Family	Code*	Allowable Discipline(s)
New or Established Client Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• problem focused history • problem focused examination • straightforward decision-making	Self limited or Minor	**Ind, Gp, & Org** 20-29 minutes	99241	<u>SD/MC</u> MD/DO <u>Network</u> MD/DO & PhD/PsyD only
	• expanded problem focused history , • expanded problem focused exam • straightforward decision-making	Low Severity	**Ind, Gp, & Org** 30-39 minutes	99242	
	• detailed history • detailed examination • decision-making of low complexity	Moderate Severity	**Indiv & Group** 40-59 minutes **Org**: 40-50 min	99243	
	• comprehensive history • comprehensive examination • decision-making of moderate complexity	Moderate to High Severity	**Indiv & Group** 60-79 minutes **Org**: NA	**Indiv & Group** 99244 **Org**: Not Reimbursed	
	• comprehensive history • comprehensive examination • decision-making of high complexity	Moderate to High Severity	**Indiv & Group** 80+ minutes **Org**: NA	**Indiv & Group** 99245 **Org**: Not Reimbursed	

*Plus CPT modifiers, when appropriate

<u>Notes:</u>

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in hours:minutes

EVALUATION AND MANAGEMENT – CONSULTATIONS, INPATIENT (MODE 15)
DEPT OF HEALTH SERVICES & NETWORK PHYSICIANS AND ADMITTING PSYCHOLOGISTS

This service may only be delivered at one of these locations: Outpatient Hospital (Place of Service Code 22)

Service	Components	Severity of Presenting Problem	Initial Consultation Code*	Confirmatory Consult Code*	Allowable Discipline(s)
Initial Inpatient or Nursing Facility Service for the evaluation and management of a new or established client that requires three components.	Problem focused history Problem focused examination • straightforward decision making	Self limited or minor	20-39 min 99251	99271	SD/MC MD/DO Network MD/DO & Admitting PhD/PsyD
	• expanded problem focused history • expanded problem focused exam straightforward decision making	Low	40-54 min 99252	99272	
Confirmatory Service to a new or established client to confirm an existing opinion regarding services. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• detailed history • detailed examination • decision-making of low complexity	Moderate	55-79 min 99253	99273	
	• comprehensive history comprehensive examination • decision-making of moderate complexity	Moderate to high	80-109 min 99254	99274	
	• comprehensive history • comprehensive examination decision-making of high complexity	high	110+ min 99255	99275	
Follow-up Inpatient Service to an established client to complete a consultation, monitor progress, or recommend modifications to management or a new plan of care based on changes in client status. At least two of three components are required. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• Problem focused history • Problem focused examination • straightforward or low complexity decision-making	Stable, recovering, or improving	1-19 minutes 99261	Not Reimbursed	
	• expanded problem focused history • expanded problem focused exam • decision-making of moderate complexity	Inadequate response to therapy or minor complication	20-29 minutes 99262	**Individual, Group, & Organizational** 20-39 minutes 90805	
	• detailed history • detailed examination • decision-making of high complexity	Significant complication or new problem	30-39 minutes 99263		

*Plus CPT modifiers, when appropriate

** Maximum reimbursement for Network Organizational MD/DO & Admitting PhD/PsyD is for 50 minutes of service.

Notes:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in hours:minutes.

SERVICES BY COMMUNITY PARTNERS (MODE 15)

Service	Code	Allowable Discipline(s)
Comprehensive Community Support (Community Partner contract providers ONLY) Specialty Mental Health Services including assessment, individual therapy, and family psychotherapy with one client present; the duration of the visit must be at least 45 minutes,	H2016	All disciplines operating within the FQHC contract

Notes:

- All of these services are classified as Individual Mental Health Services and are reported under Service Function 43.
- These services are recorded in the clinical record and reported into the IS as one unit.